



Department of Community and  
Recreation Services  
FASTRAN Division  
12011 Government Center Parkway, Suite 1040  
Fairfax, VA 22035-1115  
703-222-9764, TTY: 703-324-7079  
FAX: 703-803-8150 or 703-803-8166



The following questions and answers have been compiled to assist you in understanding the FASTRAN CRITICAL MEDICAL CARE PROGRAM (CMCP).

### WHAT IS THE CRITICAL MEDICAL CARE PROGRAM?

This service is available for Fairfax County residents who must undergo life sustaining treatments. This includes dialysis, radiology, physical therapy, chemotherapy, brain injury therapy, and water therapy.

### ARE THERE ANY FEES FOR USING THIS PROGRAM?

Yes. Fees listed below are based on household size and gross income:

<u>Household Size</u>	<u>For Income Up To and Including:</u>			<u>For Income Over:</u>	
	225%	300%	375%	450%	451%
1	\$20,948	\$27,930	\$34,913	\$41,895	\$41,988
2	\$28,103	\$37,470	\$46,838	\$56,205	\$56,330
3	\$35,258	\$47,010	\$58,763	\$70,515	\$70,672
4	\$42,413	\$56,550	\$70,688	\$84,825	\$85,014
5	\$49,568	\$66,090	\$82,613	\$99,135	\$99,355
6	\$56,723	\$75,630	\$94,538	\$113,445	\$113,693
One Way Fare	\$ 0.00	\$ 2.00	\$ 3.00	\$ 4.00	\$ 5.00

### WHAT ARE ACCEPTED FORMS OF INCOME VERIFICATION?

It is not necessary for applicants to submit income verification if that applicant is receiving services from one of the following agencies listed below (these service agencies can verify your income.)

- o you are a client of the Department of Family Services, the Health Department or Housing and Community Development OR
- o you are living in federally subsidized housing and your rent is based on your income.

Applicants who are not able to have their income verified by one of the above agencies must submit documentation. Accepted forms of documentation are (copies are acceptable):

- o letter of award from Social Security Administration
- o unemployment or Workman's Compensation statement
- o agreement showing amount of child support or alimony
- o statement of monthly pension benefits
- o employer statement(company letterhead) stating your salary or most recent pay stubs
- o bank statement showing automatic deposit of Social Security check, SSI check, and/or retirement benefits.

Parents income is not considered when determining eligibility for an adult child (18 and over) still residing at home. Also, eligibility for elderly residents residing with a child is determined solely on the applicant's income.

Example A: In a family of three (two adults and an 18 year old) the income of the two adults is not considered in determining the eligibility of the 18 year old.

Example B: An elderly couple residing with their adult children will not have their children's income considered when determining eligibility.

#### HOW WILL I KNOW IF MY APPLICATION HAS BEEN RECEIVED?

You will be sent notification through the U.S. Mail which states:

- o your application has been approved and you are certified for use of FASTRAN CMCP, or
- o that the application is incomplete and what information is required to complete the application.

#### WHERE CAN FASTRAN TAKE ME?

FASTRAN can take you to locations in Fairfax County as well as locations in Arlington County and the City of Alexandria. Rides are also available to two dialysis centers located in Sterling (Loudoun County).

#### CAN FASTRAN TRANSPORT ME IF I USE A WHEELCHAIR?

FASTRAN vehicles are lift equipped for riders with wheelchairs. Steps into the interior of FASTRAN vehicles have been specifically designed to accommodate the disabled. Lifts and tie-downs accommodate most commonly used wheelchair models. Collapsible wheelchairs are provided on request for persons with "scooter" motorized wheelchairs that cannot be transported. In this case, you will be transferred to a collapsible wheelchair and your "scooter" wheelchair will be loaded and transported.

#### WHAT ARE FASTRAN'S CMCP HOURS?

CMCP vehicles are generally available from 6:00 a.m. to 6:00 p.m. Actual hours of service are scheduled on an individual basis when you register.

#### I REQUIRE A COMPANION WHEN I TRAVEL. MUST MY COMPANION ALSO REGISTER WITH FASTRAN IN ORDER TO RIDE ON THE VEHICLE?

No. A companion does not need to be registered.

#### AM I GUARANTEED A SEAT ON A FASTRAN BUS ONCE I AM REGISTERED FOR CMCP?

Service is provided on a space-available basis.

#### ARE THERE ANY RESTRICTIONS IN WHERE I MAY RECEIVE DIALYSIS TREATMENT?

FASTRAN should transport to the dialysis center closest to a client's home. Clients should ask their nephrologist about the dialysis facilities where they practice. It may impact on whether FASTRAN will be available.

If you have a disability which prevents you from using Metro/Connector service, you may also be eligible for Metro Access service. Call Metro Access at (301) 588-8181 for more information.

## FASTRAN CRITICAL MEDICAL CARE PROGRAM

Department of Community and Recreation Services

## FASTRAN Division

12011 Government Center Parkway, Suite 1050

Fairfax, Virginia 22035-1115

703-222-9764, TTY: 703-324-7079

FAX: 703-803-8150

ID # \_\_\_\_\_

Date\_\_\_\_\_

**(OFFICE USE ONLY)**

**NOTE: AN APPLICATION MUST BE FILLED OUT FOR EACH APPLICANT**

Name: \_\_\_\_\_ Social Sec. # \_\_\_\_\_

LAST FIRST MI

Telephone #(     ) \_\_\_\_\_ (     ) \_\_\_\_\_  
HOME WORK

Address \_\_\_\_\_ Zip Code \_\_\_\_\_

Emergency Contact\_\_\_\_\_ Daytime Phone #\_(\_\_\_\_)\_\_\_\_\_

Relationship\_\_\_\_\_ Family Size \_\_\_\_\_

Sex: (Circle)                      M                      F                      Date of Birth \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_

M                      D                      Y

Will you be in a wheel chair / motorized chair on Fastran?                                          

YES NO

Is your rent based on your income?                                          

YES NO

Are you currently a client of the Department of Family Services?                       Health Department                        
YES NO YES NO

Housing and Community Development?	YES	NO
1. Do you have a home?		
2. Do you have a place to live?		
3. Do you have a place to live that is safe?		
4. Do you have a place to live that is healthy?		
5. Do you have a place to live that is affordable?		
6. Do you have a place to live that is accessible?		
7. Do you have a place to live that is secure?		
8. Do you have a place to live that is comfortable?		
9. Do you have a place to live that is convenient?		
10. Do you have a place to live that is clean?		
11. Do you have a place to live that is well-maintained?		
12. Do you have a place to live that is in a safe neighborhood?		
13. Do you have a place to live that is in a healthy neighborhood?		
14. Do you have a place to live that is in an affordable neighborhood?		
15. Do you have a place to live that is in an accessible neighborhood?		
16. Do you have a place to live that is in a secure neighborhood?		
17. Do you have a place to live that is in a comfortable neighborhood?		
18. Do you have a place to live that is in a convenient neighborhood?		
19. Do you have a place to live that is in a clean neighborhood?		
20. Do you have a place to live that is in a well-maintained neighborhood?		

If YES, County Agents' name \_\_\_\_\_

County Agency \_\_\_\_\_ Telephone # \_\_\_\_\_

ARE YOU A MEDICAID RECIPIENT? IF YES, Medicaid # \_\_\_\_\_

**CRITICAL MEDICAL CARE PROGRAM APPLICATION (cont.)**

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**INCOME STATUS**

**PLEASE INDICATE THE SOURCE, AMOUNT, AND SUBMIT PROOF OF MONTHLY INCOME:**

<b><u>SOURCE OF INCOME</u></b>	<b><u>MONTHLY AMOUNT</u></b>
AID TO DEPENDENT CHILDREN (ADC)	_____
GENERAL RELIEF (GR)	_____
REFUGEE ASSISTANCE	_____
SUPPLEMENTAL SECURITY INCOME (SSI)	_____
SOCIAL SECURITY DISABILITY INSURANCE (SSDI)	_____
SOCIAL SECURITY AWARD (SSA)	_____
RETIREMENT / PENSION	_____
WORKMAN'S COMPENSATION	_____
UNEMPLOYMENT COMPENSATION	_____
CHILD SUPPORT	_____
ALIMONY	_____
MONTHLY DIVIDENDS	_____
EMPLOYMENT	_____
OTHER INCOME IF NOT LISTED ABOVE	_____

**\*\*IF EMPLOYED, NAME AND PHONE # OF  
EMPLOYER\_\_\_\_\_**

**\*\* I DO AFFIRM TO THE BEST OF MY KNOWLEDGE THAT ALL THE ABOVE INFORMATION IS TRUE. IN ADDITION, I UNDERSTAND THAT MY SIGNITURE ON THIS APPLICATION GIVES PERMISSION TO THE FAIRFAX COUNTY COMMUNITY AND RECREATION SERVICES, TRANSPORTATION DIVISION TO MAKE CONTACT WITH OTHER HUMAN SERVICE RELATED AGENCIES FOR DETERMINING ELIGIBILITY FOR THE FASTRAN CRITICAL MEDICAL CARE PROGRAM.**

\_\_\_\_\_  
**APPLICANT SIGNATURE**

\_\_\_\_\_  
**DATE**

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